

## Maine's New Opioid Prescribing Laws & Maine's Opioid Problem

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*Confronting Maine's Opioid Crisis Conference  
March 7, 2017*



Disclosure:

**"There are no significant or relevant financial relationships to disclose."**

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Opioids:  
the difficult truth

**"We know of no other medication routinely used for a nonfatal condition that kills patients so frequently."**

NEJM: 374;16 4-21-16

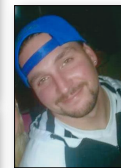
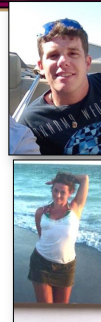
Dosage >200 MME: Number Needed to Kill = 32

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**One Death per Day**



- Maine leads nation in rate of long-acting opioid prescriptions
- Overdose death rate in Maine increased 40% from 2015 to 2016
- 272 Mainers lost to opioid/heroin deaths in 2015
- 376 overdose deaths in 2016

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**1030 Maine Babies Affected in 2016**



- Maine's infant mortality rate (7.1/1000) exceeds the national average
- 1 out of every 11 babies in Maine was born drug-affected in 2016

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**Growing Evidence of Over-Prescribing**

- C-Section patients<sup>1</sup>
  - 53% report taking no or very few (<5) opioid pills prescribed post-operatively
  - 83% report taking half or less
- Thoracic surgery patients<sup>1</sup>
  - 45% report taking no or very few (<5) opioid pills prescribed post-operatively
  - 71% report taking half or less

1: PLoS One 2016 29;11(1): e0147972. Epub 2016 Jan

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## Growing Evidence of Over-Prescribing

- Gen'l surgery patients<sup>2</sup>
  - 75% partial mastectomy pts did not take any of their prescribed opioids
  - 34% lap choly pts took no prescribed opioids
  - 45% lap inguinal hernia pts took no prescribed opioids
  - Pts reported having 67% to 85% opioid pills remaining
- Wisdom tooth extraction patients<sup>3</sup>
  - On avg, received 28 pills but used <50% of amnt rx'd
  - Extrapolates to >100 million opioid pills unused nat' ly!

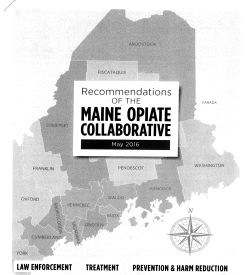
2: *Ann Surg, Hill et al, Sept 14, 2016*  
3: *Drug Alcohol Depend. 2016 Nov 1; Epub 2016 Sep 20.*

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## Maine Opiate Collaborative



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## Overview of Chapter 488

- Effective 90 days after adjournment, though some provisions have other timeframes specified (July 29, 2016)
- Components include:
  - Required PMP check for prescribers and dispensers
  - Prescribing limits on MMEs per day
  - Prescribing limits on length of scripts
  - Exception for emergency rooms, inpatient hospitals, long-term care facilities, or residential care facilities
  - Exception for medication-assisted treatment for substance use disorder
  - Exceptions for active and aftercare cancer treatment, palliative care, and end-of-life and hospice care
  - Other exceptions may be determined by rule
  - Mandatory CME
  - Mandatory electronic prescribing
  - Partial filling of prescriptions at patient request

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## Key Definitions

- Acute pain
  - Normal, predicted physiological response to a noxious chemical or thermal or mechanical stimulus.
  - Typically associated with invasive procedures, trauma and disease and is usually time-limited.
- Chronic pain
  - Persists beyond the usual course of an acute disease or healing of an injury.
  - May or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years

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## Key Definitions

- Prescriber
  - Licensed health care professional with authority to prescribe controlled substances
  - Includes veterinarians
- Administer
  - Action to apply prescription drug directly to a person
  - Does not include delivery, dispensing, or distribution of a prescription drug for later use

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## Key Definitions

- Palliative care
  - Patient-centered, family-focused medical care that optimizes quality of life by anticipating, preventing, and treating suffering caused by serious medical illness or physical injury or condition that substantially affects quality of life
  - Addresses physical, emotional, social, and spiritual needs
  - Facilitates patient autonomy and choice of care
  - Provides access to information
  - Discusses patient's goals for treatment and treatment options, including hospice care
  - Manages pain and symptoms comprehensively

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## Key Definitions

- **Serious illness**
  - Medical illness or physical injury or condition that substantially affects quality of life for more than a short period of time
  - Includes, but is not limited to, Alzheimer's disease and related dementias, lung disease, cancer and heart, renal or liver failure

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## Prescriber Responsibilities

- **Required PMP check**
  - Upon **initial** prescription of benzodiazepine or opioid medication
  - Every **90 days** following
- **Exception**
  - No PMP check is required for benzodiazepine or opioid medication **directly administered** in an emergency room setting, an inpatient hospital setting, a long-term care facility, or a residential care facility

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## Prescriber Responsibilities

- **Electronic Prescribing**
  - Beginning July 1, 2017, prescribers with the capability to electronically prescribe must prescribe all opioid medication electronically
  - A **waiver** may be available in some circumstances
- **Continuing Education**
  - Every prescriber must complete **3 hours of CME** on the prescription of opioid medication **every 2 years** as a condition of prescribing opioid medication

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## Exceptions to limits on Opioid medication prescribing

Prescribers are exempt from the limits on opioid medication prescribing established in this rule if:

1. Pain associated with active and aftercare cancer treatment. Providers must document in the medical record that the pain experienced by the individual is directly related to the individual's cancer or cancer treatment. An exemption for aftercare cancer treatment may be claimed up to six months post remission. Exemption Code A
2. Palliative care in conjunction with a serious illness (includes injury). Code B
3. End-of-life and hospice care. Code C
4. Medication-Assisted Treatment for substance use disorder. (Original 12-month limit has been removed.) Code D

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## Exceptions to limits on Opioid medication prescribing

Prescribers are exempt from the limits on opioid medication prescribing established in this rule if:

5. A pregnant individual with a pre-existing prescription for opioids in excess of the 100 Morphine Milligram Equivalent aggregate daily limit. This exemption applies only during the duration of the pregnancy. Code E
6. Acute pain for an individual with an existing opioid prescription for chronic pain. In such situations the acute pain must be postoperative or new onset. The seven day prescription limit applies; or Code F
7. Individuals pursuing an active taper of opioid medications, with a maximum taper period of six months, after which time the opioid limitations will apply, unless one of the additional exceptions in this subsection apply. Code G

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## Partial fill

Upon patient request, pharmacist may dispense lesser quantity of medication than is prescribed

- **Remainder of prescription is void**
- Pharmacist must, within 7 days, **notify** prescriber of quantity actually dispensed
- Notification may be by notation in patient's EHR, by electronic transmission or fax or telephone

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## Deadlines

- **Effective date is 90 days after adjournment (July 29, 2016)**
- **January 1, 2017**
  - Mandatory checks of the PMP
  - Limits on scripts for acute and chronic pain
- **July 1, 2017**
  - Mandatory electronic prescribing
  - Patients with active prescriptions in excess of 100 MMEs must be tapered to an aggregate amount of 100 MMEs or less per day
- **December 31, 2017**
  - CME requirement (3 Hours)

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## Penalties

- Civil violation
- Subject to fine of \$250 per incident up to a maximum of \$5000 per calendar year
- More serious concern is Board action

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## Other Provisions

- Prescription Monitoring Program (PMP)
  - PMP data access to other states and Canadian provinces (coming)
  - Automatic registration of pharmacists and veterinarians
  - "Enhancements" (New software: Appriss "PMP AWARE<sub>x</sub>E<sup>®</sup>")
    - "Dosage converter" to/from MME
    - Automatic distribution of de-identified peer data to prescribers annually
    - Improved delegation to non-prescriber staff
    - Improved speed and communication
- DHHS and Bureau of Insurance reporting requirements

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## PMP ACCESS


**DHHS:** [https://mepdm-ph.hidinc.com / melogapp/bdmeppdmqlog/pmqaccess.html](https://mepdm-ph.hidinc.com/melogapp/bdmeppdmqlog/pmqaccess.html)

**HealthInfoNet:** Single click sign-on from inside HIN for registered PMP users

- Contact HealthInfoNet Customer Care at (207) 541-9250 for an HIN account

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## Resources

MMA's Opioid Crisis page:


- <https://www.mainemed.com/advocacy/opioid-crisis>
- Opioid laws & rules, Maine Opiate Collaborative task force Reports, CDC guidelines, naloxone, Q and A.

Caring for ME page:

- <https://www.mainequalitycounts.org/page/2-1488/caring-for-me>
- Webinars, opioid laws & rules, information on pain management and tapering, etc.

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## Disclosures

- Not funded by any pharmaceutical manufacturer or seller
- MICIS is a program of the Maine Medical Association
- Program funded entirely by Maine Department of Health & Human Services
- Any opinions stated are the speaker's. The speaker is not speaking for the State of Maine or the Maine DHHS.
- EFM was a paid Peer Consultant for Maine Quality Counts' Chronic Pain Collaboratives 1&2 (2014-2016), funded by an unrestricted grant from Pfizer Independent Grants for Learning and Change (IGL&C) group.

### “Academic Detailing”

“[T]he provision of information regarding prescription drugs based on scientific and medical research, including information on therapeutic and cost-effective use of prescription drugs.”

22 M.R.S.A. §2685 (1) (A)

- Balanced, objective, evidence-based information
- Independent of commercial relationships
- Presented by trained healthcare professionals



### The Goals of Academic Detailing

On-site, Independent, Evidence-based Prescribing Tutorials, Known as “Academic Detailing”

- Change thinking about prescribing to be consistent with medical **evidence**
- Support patient **safety**
- Assist **cost-effective** medication choices
- Improve **patient care**



### Program Purpose

Established by Maine Statute 22 MRSA §2685 (2007):

- “[T]o enhance the health of residents of the State, to **improve the quality of decisions regarding drug prescribing**, to encourage better communication between the department and health care practitioners participating in publicly funded health programs and to reduce the health complications and unnecessary costs associated with inappropriate drug prescribing.”
- “[I]nclude **outreach and education regarding the therapeutic and cost-effective use of prescription drugs** as issued in peer-reviewed scientific, medical and academic research publications.”
- “To the extent possible ... include information regarding **clinical trials, pharmaceutical efficacy, adverse effects of drugs, evidence-based treatment options and drug marketing approaches** that are intended to circumvent competition from generic and therapeutically equivalent drugs.”



### Program Structure

#### Funding:

- \$500 per year fee on all pharmaceutical manufacturers selling to MaineCare (Medicaid) or Drugs for the Elderly program
- May accept funds from foundations, AG settlements, Tobacco Manufacturers Act

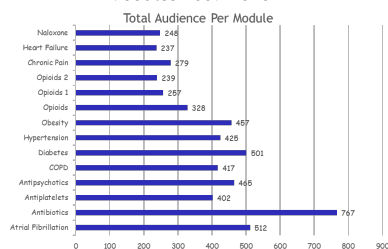
#### Contract:

- State DHHS annual contract with Maine Medical Association
- MMA established MICIS program, contracts with prescribing clinicians to provide academic detailing services
- Regular reporting of data and evaluations to DHHS



### MICIS 2017 - Opioids

#### Modules 2009-2016



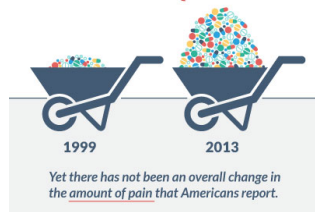
### MICIS Take Home Points

- Free CME
- Delivered on-site—office, hospital, conference
- Groups of 1 to >100
- Independent of commercial interests
- Focused on the available data & evidence
- Presented by prescribing clinicians



## PROBLEM

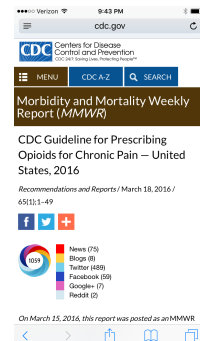
From 1999 to 2013,  
the amount of prescription opioid pain relievers  
prescribed & sold in the U.S. nearly  
**QUADRUPLED.**



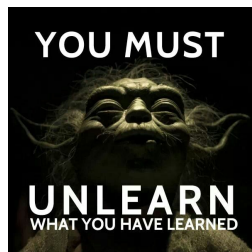
From CDC website

## National Response—March 2016

- Reversing the epidemic requires changing the way opioids are prescribed
- CDC's Injury Center developed evidence-based guidelines for opioid prescribing



## THE HEALTHCARE FORCE AWAKENS



## Opioids go beyond NNT & NNH: NUMBER NEEDED TO **KILL**

- All comers on opioids: NNK=550
- Doses >200 MME: NNK=32

Median time from first opioid rx  
to death: 2.6 years

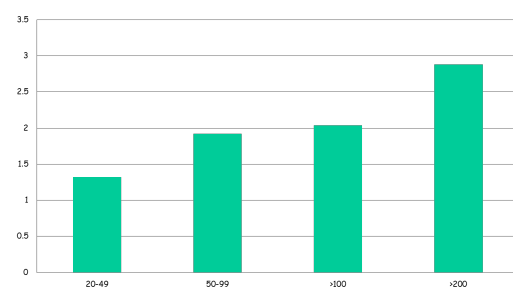
Freiden. NEJM: 374;16:1501-4

Maine worse than most: 1.5% of adult  
population on >100 MMEs

## Chapter 488 is Evidence-based!

- Limits on script duration (7/30d)
- Mandatory PMP check (opioids/BZDP)
- 100 MME daily limit
- Required CME
- E-prescribing (Schedule II)

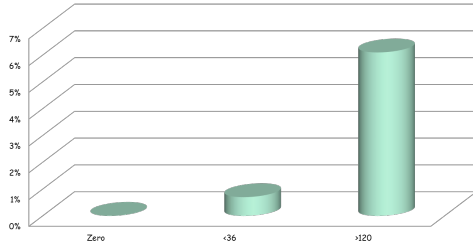
## RISK OF FATAL OVERDOSE (including accidental)



Gomes. Arch Intern Med 2011;171:686-91.

## **OUD RISK RISES WITH MME**

Prevalence of OUD by MME Dose



Donnell. MMWR 2016;65(1):9.

## **“UNDERAPPRECIATED CONTRIBUTION”**

Benzodiazepines thought to be associated with nearly 80% of opioid overdose deaths



Gudin. Postgrad Med 2013; 125(4):115-130.

## **Academic Detailing**

- 1:1 interaction between a specially trained healthcare professional & a prescriber
  - Identifies current practice/knowledge base
  - Updates on current evidence
  - Describes features and benefits
  - Overcomes objections & barriers
  - Secures commitment



## **Educational Outreach**

- Uses evidence & presents best practices and guidelines
- Smaller audiences preferred but larger possible
- Adult learner focused
  - Case-based study
  - Multi-media
  - Small group discussion



## **2017 Offerings for Opioid Education**

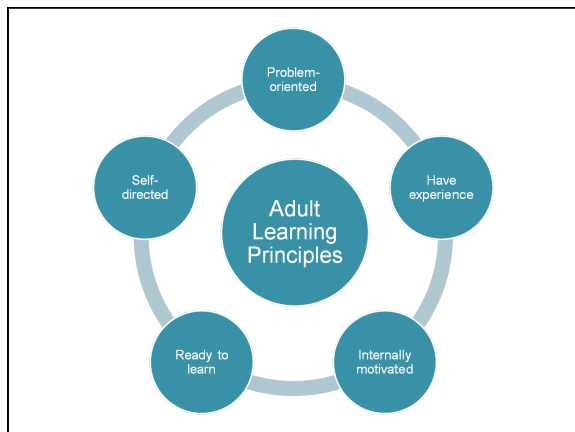
- Large group workshops
- Individual or small group AD sessions
- Collaboration to produce webinars
- QI recommendations & resources
- Enhanced web resources for chronic pain
- Guidance on formation of “CSI’s”



## **Large Group Workshop**

- Six 0.5 CME clinical topics
  - Genesis of epidemic & Opioid misuse
  - Basics: MMEs & Tapering
  - Practice Transformation
  - Harm Reduction
  - Communication Skills
  - Non-opioid & Non-pharm Options
- 0.5 or 1.0 CME on opioid prescribing law





## Workshop Elements

- Multimedia, including video “blitz” didactics from Maine leaders in Opioid Education
- Case-based studies
- Small group discussion
- Action planning
- “un-advertisement”



Welcome to newly-designed CME, created by and for practicing clinicians, modeled to change practice behaviors with a compassionate, patient-centered perspective and focused on combating the defining public health crisis of our generation.



## Example of Multimedia Use in Workshop

- “Treat Yourself” by Zdogg MD  
[www.youtube.com/watch?v=0Aa1clWcFOc](https://www.youtube.com/watch?v=0Aa1clWcFOc)  
Used with permission
- While watching the video, look for
  - Origins of opioid epidemic
  - Signs of OUD
- After video participants answer discussion questions in small groups

**LESS MEDICINE  
MORE HEALTH**



## Questions?

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